Women's Health Intake

Client ID: _____

Admission ID: _____

Client's name *(first, middle, last)*: _____ Maiden name: _____

Client alias: _____ Alias Client ID: _____

ID Number	ID Type

Birth date: ____/____/____ Medicaid ID: _____ Other IDs:

Street address: _____ Apt# _____ County: _____

City: _____ State: _____ Zip code: _____

Cell phone: _____ Alternate phone: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Primary Race: *(enter option from race table below)* _____

Race:

(Check all that apply)

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black
- ☐ Native Hawaiian/Other Pacific
- ☐ White
- ☐ unknown
- ☐ other specify _____

Is participant of Hispanic/Latino descent? ☐ yes ☐ no

Country of Origin: *(if Hispanic/Latino)*

- ☐ Central America
- ☐ Cuba
- ☐ Mexico
- ☐ Puerto Rico
- ☐ South America
- ☐ Unknown
- ☐ other specify _____

Ethnicity:

- ☐ African American
- ☐ African (not Sudanese)
- ☐ African (Sudanese)
- ☐ American
- ☐ Asian (other)
- ☐ Asian (Burmese)
- ☐ Asian (Vietnamese)
- ☐ Bosnian
- ☐ Chinese
- ☐ Croatian
- ☐ Haitian
- ☐ Hispanic/Latino
- ☐ Jamaican
- ☐ Korean
- ☐ Micronesian
- ☐ Somalian
- ☐ unknown
- ☐ other specify _____

Languages spoken:

- ☐ American Sign Language
- ☐ Bosnian
- ☐ Chinese
- ☐ English
- ☐ Serbian
- ☐ Spanish
- ☐ Sudanese
- ☐ Vietnamese
- ☐ unknown
- ☐ other specify _____

Is English the primary language? ☐ yes ☐ no ☐ unknown

Is a translator needed? ☐ yes ☐ no ☐ unknown If yes, what language? _____

Date of contact: _____

How did client hear of services? *(choose all that apply)*

- ☐ birthright
- ☐ education/school/AEA
- ☐ family planning
- ☐ friend/relative
- ☐ medical clinic
- ☐ other participant
- ☐ primary care provider
- ☐ school nurse/counselor
- ☐ shelter
- ☐ walk-in /self-referral
- ☐ WIC
- ☐ unknown
- ☐ hospital (specify) _____
- ☐ other (specify)_____

Will services be provided? ☐ yes ☐ no

If no, reason not served:

- ☐ eligibility guidelines not met
- ☐ out of service area
- ☐ not pregnant
- ☐ services refused
- ☐ other specify _____

Client consent form signed? ☐ yes ☐ no Date signed: _____/_____/_____

Subcontractor assigned: _____County Assigned_____

Client Name: _____ Birth Date: _____Medicaid ID: _____

Primary Payment Source: *(enter option from payment source table below)* _____

Secondary Payment source: *(check all that apply)*

□ Medicare □ private insurance □ uninsured
□ Medicaid/Title XIX □ self-pay/sliding scale □ other specify _____
□ presumptive eligibility □ Title V

WIC certified at admission? □ yes □ no □ unknown

Employment: □ full time □ part time □ unemployed

Current marital status:

□ divorced □ separated □ single □ unknown
□ married □ single □ widowed

Highest grade participant completed:

□ 8th grade or less □ high school graduate □ college degree
□ 9th grade □ GED □ technical training
□ 10th grade □ some college □ other
□ 11th grade

Health History Indicate if client or family member has a history of any of the following

Disease	Client	Family Member	Comments
Diabetes	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
High Blood Pressure	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Heart Disease (including heart attack, stroke)	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Breast Cancer	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Cervical Cancer, Uterine Cancer or Ovarian Cancer	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Other Cancer	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Arthritis	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Osteoporosis	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Lung Disease (including asthma, emphysema)	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Periodontal Disease	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Hepatitis C or Hepatitis B	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
HIV or AIDS	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Mental Illness (including anxiety or panic disorder, depression, bipolar disorder, schizophrenia, etc.)	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Sexually Transmitted Diseases	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Anemia	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	
Tuberculosis	□ yes □ no □ unknown □ client declines to answer	□ yes □ no □ unknown □ client declines to answer	

Client Name: _____ Birth Date: _____Medicaid ID: _____

Health And Risk Assessment

Does client have any of the following risk factors?

- □ lack of or minimal physical activity
- □ multiple sexual partners/same sex partner/unprotected sex
- □ overweight/obesity
- □ substance abuse (alcohol or drugs)
- □ tobacco smoking or chewing
- □ underweight

Health Screenings Completed

Indicate if the client has had any of the following health screenings. If yes, enter the date of the screening.

Mammogram	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Clinical breast exam	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Pelvic exam, including Pap Smear	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Oral health assessment	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Colonoscopy or Sigmoidoscopy	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Fecal Occult Blood test	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Blood pressure check	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Bone Mineral Density test	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Skin exam (mole, etc.)	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Eye exam, including glaucoma screen	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____

Lab Work

Thyroid test (TSH)	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Cholesterol	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____
Glucose	□ yes	□ no	□ unknown	If yes, date of screening: _____/_____/_____

Immunizations: Are the following immunizations up to date?

Tetanus Diphtheria	□ yes	□ no	□ unknown	If yes, date: _____/_____/_____
Influenza vaccine	□ yes	□ no	□ unknown	If yes, date: _____/_____/_____
Pneumococcal vaccine	□ yes	□ no	□ unknown	If yes, date: _____/_____/_____
Hepatitis B vaccine	□ yes	□ no	□ unknown	If yes, date: _____/_____/_____
Rubella vaccine	□ yes	□ no	□ unknown	If yes, date: _____/_____/_____
Varicella	□ yes	□ no	□ unknown	If yes, date: _____/_____/_____

General comments:_____

_____

_____

_____

_____

Intake form completed by:		
Data entered by:		
Quality assurance inspection:		